Best Practice: *Quality Counseling by General Health Care (GHC) Staff for Giving Supervised Single-Dose Rifampicin (SDR) to Close Contacts of Index Cases in Dadra and Nagar Haveli (DNH), India*

Subthemes

- PEP / people at risk
    - Implementation phase

Target Audience(s)

- Program managers
- Trainers
- Health staff
- Persons affected by leprosy

Contributors

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Key Messages

Counseling by General Health Care (GHC) staff of index cases and their healthy contacts resulted in acceptance of single-dose rifampicin (SDR) by 90% of them. Counseling of a few community leaders by GHC and project staff led to garnering support from the community, reduction of stigma, and improved perception.

Key Informant / Date Submitted

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Description of the Best Practice

Introduction

The integrated counseling and testing centers (ICTC) under HIV prevention and control programs demonstrated that pre-test HIV counseling led to increased acceptance for HIV screening / rapid testing and promoted behavioral change. This triggered the idea of introducing counseling in leprosy post-exposure prophylaxis (LPEP). The leprosy perception study (see #2 below, **Further Readings**) had revealed that there were myths and misconceptions about leprosy and poor involvement of community leaders, indicating the need to adopt counseling as a key intervention prior to initiation of enrollment of index cases and contacts in the study.

Problems that could be solved by counseling include

- Prevailing myths and misconceptions about leprosy in the community
- Poor health-seeking behavior in the community, such as many members who favored informal practitioners
- Reluctance of leprosy patients (index cases) to disclose themselves as leprosy cases
- Reluctance of healthy contacts to take SDR
- Reluctance of GHC staff to perform extra work
- Poor understanding about the benefits of LPEP by the community

Impact of the problem on the population

The implementers were unsure whether patients would reveal their condition or accept SDR at the desired level. The myths and prejudices about leprosy were the main barriers in ensuring acceptance of SDR by healthy contacts who had no symptoms of leprosy. If SDR was not fully accepted, the incomplete coverage of LPEP might not give desired results toward stopping the chain of transmission.

Relevance for leprosy control

It has already been demonstrated in the HIV/AIDS control program that counseling was the key intervention to improve acceptance for undergoing HIV screening using a rapid test kit. It had also helped to convince and motivate high risk or vulnerable persons to adopt safer behavioral practices, and, if test results were found positive, to go for further tests and treatment. Persons affected by leprosy faced a similar level of societal stigma and discrimination as faced by persons with HIV/AIDS. Hence, it was decided that counseling could be used to change the outlook against persons affected by leprosy by equipping them with correct knowledge and information and enabling informed decisions by contacts.

Objectives achieved

As a result of the counseling sessions, the following objectives were achieved:

- Provision of informed consent and of names of contacts by index cases
- Acceptance by contacts to readily take SDR
- Cooperation with staff, even during follow up visits
- Changed perceptions of community members as they became aware of leprosy-related facts, which improved voluntary self-reporting by suspected cases

Objectives and Methodology

The main goal and objectives of implementing this practice pertained to 1) the acceptance by eligible contacts for screening and taking SDR; 2) the garnering of support from the community to implement LPEP; and 3) the involvement of GHC staff for follow up of contacts who had taken SDR and maintained records.

Methodology used

- Available GHC staff and accredited social health activists (ASHAs) were given counseling training that involved role playing and education on communication skills, criteria and role of a good counselor, implications of counseling, etc.
- During trainings, staff were provided handouts on counseling for easy reference
- GHC staff conducted counseling during household visits, and the process was also supervised by respective supervisors
- Counseling/communication materials were developed in local/vernacular language

Was the design based on evidence?

Yes, counseling has been found to be very effective and is a mainstay before undertaking any HIV test to improve test acceptance.

Implementation of Practice

Main activities

- Training of GHC staff on counseling and techniques, etc.
- Counseling of index cases prior to obtaining informed consent for enrollment in the study and for giving names of their close contacts
- Counseling of contacts of index cases for screening and examination prior to taking SDR, if leprosy is ruled out. The counseling took on average 30 minutes per session per contact, which included screening in some cases.
- Counseling of a few community members to develop a conducive environment for LPEP
- Supervision of the counseling process by immediate supervisors, including auxiliary nurse midwives (ANMs), paramedical workers (PMWs), and project staff (i.e., research assistants)

The activities were carried out in Dadra and Nagar Haveli (DNH), a union territory in the western part of India, from March 2015 until June 2018.

Were persons affected by leprosy participating in the design and practice itself?

Yes, peer counseling by persons affected by leprosy was promoted. The persons affected by leprosy who participated in the study, such as index cases, were counseled to help other index cases living in their locality and villages list their respective contacts and to let the community know that leprosy could be prevented through the LPEP project.

Key implementers and collaborators

The key implementers were the GHC staff from the Govt. of DNH and community volunteers. The state leprosy officer and local medical officers (MOs) were involved in monitoring and supervision of the project. The collaborators were NLR India, GLRA India, NLR Amsterdam, and EurMC, Rotterdam, and included persons affected by leprosy. Central Leprosy Division, Govt. of India, and Indian Council of Medical Research, MoH, were involved in monitoring the progress of project. NLR Amsterdam coordinated the project internationally, and Novartis Foundation was the funding agency.

Resource implications

Since the project was implemented by the GHC staff, no major expenditure was incurred. The cost of training and materials on counseling was covered by the project fund.

Results—Outputs and Outcomes

What were the concrete results achieved with regard to outputs and outcomes?

A total of 1662 index cases were reported, of whom 1643 were enrolled in the study. Among the 19 cases who were excluded, 10 refused to participate due to fear of disclosure, 7 lived outside the LPEP area, and 2 had no contacts. All 1643 enrolled index cases were counseled and helped to come out from the dilemma of exposing their identity as leprosy affected persons. These individuals listed a total of 43,305 contacts, of whom 42,333 (97.7%; 20,894 male and 21,439 female) were counseled and screened by the trained and motivated GHC staff comprising PMWs, multi-purpose workers, ANMs, and, in some cases, research assistants. Of the 42,333 screened contacts, 30,295 (93.9%) received SDR. The community members also contributed in tracing contacts by providing counseling and administration of SDR after their acceptance to enroll in the study.

Were data management processes of the best practice consistent and transparent to draw conclusions?

Since counseling was one of several activities of the LPEP project implementation and had been integrated into the routine system in the intervention areas, no data were recorded related to numbers of counseling sessions done or number of persons with improved attitudes and positive behavioral changes. However, it could be presumed that the total number of enlisted and enrolled index cases (i.e., 1643) and their close contacts (i.e., 42,333) represented the total number of counseling sessions provided by staff, if one counseling session per index case or contact was taken as the surrogate indicator.

Was an assessment of the practice carried out? If yes, what were the results?

There was no assessment of the practice. The results were found in the form of improved or positive behavioral changes and attitudes and better practices of GHC staff, ASHA, and community members that resulted in enhanced motivation of staff in general and improvement in leprosy patients' willingness to list their contacts.

Is the project completed or are some results still to be expected?

The project was completed in June 2018.

Lessons Learned

What worked really well?

Among the activities that worked really well was the involvement of a dedicated and motivated team of GHC staff and ASHAs who carried out tracing of index cases and their contacts and provided them proper counseling to take part in the study. The trainings organized for them were well planned under the guidance and leadership of the State Leprosy Cell and Directorate of Health Services of DNH. The well-functioning health system and mechanism to train and manage the health workers' performance on counseling activities resulted in the high enrollment and coverage of subjects (index cases and contacts) under LPEP. This model could be replicated in other aspects of counseling services for voluntary reporting of suspected cases; ensuring MDT compliance; self-care practices; and reducing stigma and discrimination towards persons affected by leprosy, etc.

What did not work?

The majority of activities under the counseling services had worked, apart from certain resistance faced initially from a few GHC staff, community members, and index cases. However, most of these persons supported the entire gamut of activities. The resistance faced was primarily due to apprehension by few individuals about the provision and intake of the drug, as knowledge about leprosy, LPEP, and its benefits versus risks were poor among certain sections.

Replicability and Scalability

Has the practice been implemented in more than one setting?

Yes, the practice is being replicated in other parts of DNH since the second half of 2018, as it got fully integrated in routine National Leprosy Elimination Programme (NLEP) activities by the Govt. of DNH.

What long term effects can be achieved, if the practice is sustained over time?

If the practice is sustained over time, not only would the enrollment coverage and quality of LPEP-SDR administration be very high but the overall NLEP would improve as demonstrated in DNH.

What are the requirements to sustain the practice over time considering contextual factors, institutional support, human resources?

To sustain the practice over time, the requirements would be the availability of counseling guides and materials, effective trainers, and good teaching aids such as audio-visual materials on the counseling process, use of role plays, testimonials, and sharing of experiences and successful case stories, etc., by persons affected and the implementers, along with the availability of well-trained and motivated GHC staff who could carry out counseling activities. Ensuring the availability of these requirements would improve the counseling services.

Conclusions

How have the results benefited the population?

The perception of the population has changed positively, and the population is convinced that leprosy is preventable.

Why may that intervention be considered a "best practice"?

The counseling techniques were not routinely used under NLEP or any other leprosy project but counseling had yielded good results in terms of achieving the targets of coverage, so it could be considered as a "best practice."

What recommendations can be made for those intending to adopt the documented "best practice" or how can it help people working on the same issue(s)?

- Buy-in from the key stakeholder (i.e., local government) for using counseling as one of the strategies under LPEP
- Acceptance by GHC staff to provide counseling services as part of LPEP and ensuring that they participate in the trainings
- Prior preparation of all materials required for counseling activities including training requirements
- A well-planned training strategy that takes into account the availability of good trainers/experts on counseling to improve health outcome; the development and availability of training materials in vernacular languages
- Cascade training plan and implementation
- Sensitization of community leaders/members and even counseling for some who may be more skeptical of using counseling prior to taking informed consent and revealing names of their close contacts, etc.
- On-job supervision of GHC staff

Further Readings

1. WHO. Guidance on Testing and Counselling for HIV in Settings Attended by People Who Inject Drugs: Improving Access to Treatment, Care and Prevention. Geneva: World Health Organization, 2009. Accessed at https://www.ncbi.nlm.nih.gov/books/NBK305381/
2. Peters R, Mieras L, Subedi M, Apte H, Koesbardiati T, Banstola NL, Das S, van Brakel W. A single dose of rifampicin to prevent leprosy: qualitative analysis of perceptions of persons affected, contacts, community members and health professionals towards chemoprophylaxis and the impact on their attitudes in India, Nepal and Indonesia. Lepr Rev 2018;89:335–352.